Telehealth: rapid adoption in community palliative care due to COVID-19: patient and professional evaluation

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ABSTRACT

Background/objective The COVID-19 pandemic has brought the use of telehealth to the fore, as many people have been unable to interact directly with healthcare professionals (HCP). For community palliative care (CPC) services, this has meant a sudden change from a predominantly face-to-face model of care to one that incorporates telehealth. Understanding patient and HCP experiences with telehealth and how telehealth compares to 'usual' care will be crucial in planning future CPC services.

Methodology All patients of the Barwon Health CPC service between 1 April and 31 May 2020 were invited to complete a questionnaire evaluating their interactions with the palliative care service and specifically their involvement with telehealth consultations. Palliative care HCP who provided clinical services during the same time period were also surveyed.

Results/conclusion Seventy-four patients (response rate 36%) and 22 HCP returned surveys. Both groups felt comfortable using telehealth, however, also encountered a range of issues when undertaking telehealth consultations. Despite reporting issues, the preference of both groups was for a CPC service model, which combined face-to-face and telehealth consultations. This study is one of the first to directly ask this question and as such provides useful guidance for health services when planning future CPC service models.

Key message

What was already known?
- Telehealth is increasingly used in palliative care.
- Satisfaction with, and barriers to use have been identified.

What are the new findings?
- Community palliative care (CPC) patients and healthcare professionals were supportive of telehealth utilisation.
- A CPC service model that combined telehealth with face-to-face visits was favoured.

What is their significance?
- Identification of barriers allows ongoing service enhancement.
- Future CPC service models should combine face-to-face and telehealth consultations.

Telehealth is being increasingly used in healthcare settings including palliative care.[1–4] Defined as the provision of personalised healthcare using telecommunication means,[1–3] telehealth can incorporate any combination of telephone, videoconference and remote monitoring technologies.[3] While data remain limited,[4] there is evidence suggesting telehealth can play a role in community palliative care (CPC) practice.

Patients, caregivers and healthcare professionals (HCP) have reported both satisfaction with telehealth[1–13] and barriers to its effectiveness.[3 4 6 13–15] Reported benefits have included improved access to care for debilitated and remote patients and reduced hospitalisations and travel. Barriers have included technological difficulties, potential degradation of the patient–clinician relationship and limitations on capacity to have 'difficult' discussions. These conversations, which typically revolve around end-of-life care and prognosis, are core features of palliative care practice and, therefore, approaches that allow them to occur appropriately are salient for CPC services.

The Barwon Health CPC service has traditionally relied on face to face (F2F)

visits as the primary mode of service delivery with limited use of telehealth. The COVID-19 pandemic meant that the service, was required to make a sudden change to a model where most patient contacts occurred via telehealth. Given the likelihood of future pandemic events, it appears telehealth will remain an important component of healthcare provision and by extension palliative care practice. The aim of the current project was to understand patient and HCP perspectives on the use of telehealth within CPC practice. It was anticipated that this would support the optimisation of local care provision as well as provide guidance to other services.

METHODOLOGY

Barwon Health is one of the largest regional health services in Australia. All Barwon Health CPC and ambulatory care patients registered with the service between 1 April and 31 May 2020 were eligible for participation. These dates corresponded to the commencement of COVID-19-related changes at Barwon Health, which included the substitution of ambulatory clinics with telehealth and the requirement for community services to use telehealth where possible. Palliative care HCP who provided clinical services to either CPC and/or ambulatory care patients during the same time period were also eligible to be involved.

The survey was developed by the research team, underwent peer and consumer-review and was amended based on feedback. Given the unprecedented and highly stressful times, the survey was designed to be easy to undertake so as not to burden recipients.

A 'telehealth consultation' was defined as any interaction, lasting more than 10 min, between a patient and a palliative care HCP using a telecommunication device. For those who had engaged with telehealth, questions asked about the interactions with palliative care services, type/frequency of telehealth used, comfort with and issues encountered with telehealth, comparison with F2F contacts and preferred model of care. Involvement was voluntary and anonymous with consent inferred from study completion.

The survey, with an enclosed explanatory letter and prepaid envelope, was mailed to all eligible patients. Survey distribution to HCP was via email containing a link to the survey and an explanatory letter. Data were analysed descriptively with additional themes derived from analysis of free-text responses. Ethical approval was obtained from the Barwon Health Research, Ethics and Integrity Unit (Project number 20/106) and a Western Alliance Academic Health Science Centre COVID-19 Research Grant supported the project.

RESULTS

Patient respondents

The survey was sent to 205 patients with 74 questionnaires returned (response rate 36%). Seventy-eight per cent of respondents had used telehealth during the period in question. The median age of those respondents was 75, 57% were men, and the majority were pre-existing patients with CPC. Sixty-four per cent of patients reported their telehealth consultations had been via telephone alone while 72% of HCP had used both telephone and video conferencing (data not shown).

The majority of patients did not have issues with telehealth, with 71% reporting their needs were able to be met (table 1.). For those who did have issues, free-text responses revealed the most common reported themes related to existing sensory deficits, technological problems and feeling under educated using the system. Most patients either favoured or were neutral regarding their preference for F2F visits over telehealth and 60% indicated their preferred model for future CPC service provision was a combination of F2F and telehealth consultations.

HCP respondents

Twenty-two HCPs responded to the survey with 18 involved in telehealth consultations during the study period. Of these a third were nurses. Fifty-four and 41% of HCP reported having issues with video conferencing and telephone calls, respectively. The predominant telephone-related issues were an inability to observe facial cues/body language and difficulty establishing a therapeutic relationship. In contrast, concerns about video conferencing centred on patient engagement with a 'new' technology and technological problems. Most HCP preferred video conferencing to telephone calls and all preferred F2F interactions to telehealth. Despite this 89% indicated a preference for ongoing service provision to combine F2F and telehealth consultations.

DISCUSSION

In Victoria, concerns around community transmission of COVID-19 in early 2020 necessitated sudden changes in healthcare provision. This included a shift away from direct patient contact to remote modes of consultation. For the Barwon Health CPC service, like many such services, this was a particularly dramatic change, as traditionally the majority of patient–clinician interactions were F2F. This change occurred almost overnight and as such meant many patients had an experience of interaction with both models of care in relative 'real time'. This represents a point of difference with previous studies that have reported on patient and/or HCP interactions with telehealth, as these studies have tended to evaluate pre-established or specifically developed telehealth programmes.[5 7]

The majority of respondents felt comfortable with telehealth palliative care consultations and indicated the issues that needed to be discussed could be covered. While patients were ambivalent about their preference between telephone calls and video conferencing, HCP very much favoured the latter. This preference for

Table 1 Patient and HCP responses to key questions investigating their interactions with, and opinions of, telehealth consultations

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not answered
I had issues undertaking telehealth consultations via telephone calls*?[A]	**Patients**	17 (34%)	16 (32%)	6 (12%)	9 (18%)	1 (2%)	1 (2%)
	HCP	2 (12%)	6 (35%)	2 (12%)	5 (29%)	2 (12%)	0 (0%)
I felt comfortable undertaking telehealth consultations via telephone calls?	**Patients**	2 (4%)	4 (8%)	5 (10%)	24 (48%)	14 (28%)	1 (2%)
	HCP	1 (6%)	2 (12%)	2 (12%)	11 (65%)	1 (6%)	0 (0%)
I prefer face to face visits to telehealth consultations via telephone calls?	**Patients**	2 (4%)	4 (8%)	16 (32%)	14 (28%)	11 (22%)	3 (6%)
	HCP	0 (0%)	0 (0%)	0 (0%)	9 (53%)	8 (47%)	0 (0%)
I had issues undertaking telehealth consultations via video conference?*	**Patients**	4 (22%)	6 (33%)	1 (6%)	4 (22%)	2 (11%)	1 (6%)
	HCP	1 (7%)	4 (29%)	1 (7%)	8 (57%)	0 (0%)	1 (7%)
I felt comfortable undertaking telehealth consultations via video conference?	**Patients**	1 (6%)	0 (0%)	2 (11%)	8 (44%)	7 (39%)	0 ()%)
	HCP	0 (0%)	2 (14%)	0 (0%)	8 (57%)	4 (29%)	0 (0%)
I prefer face to face visits to telehealth consultations via video conference?	**Patients**	1 (6%)	2 (11%)	8 (44%)	5 (28%)	2 (11%)	0 (0%)
	HCP	0 (0%)	0 (0%)	1 (7%)	7 (50%)	6 (43%)	0 (0%)
I prefer telehealth consultations via video conference to telehealth consultations via telephone?	**Patients**	2 (11%)	3 (17%)	4 (22%)	4 (22%)	3 (17%)	2 (11%)
	HCP	1 (8%)	1 (8%)	0 (0%)	6 (46%)	5 (38%)	1 (8%)
Overall I felt the issues that needed to be discussed were able to be covered using telehealth consultations?	**Patients**	3 (5%)	2 (3%)	5 (9%)	23 (40%)	18 (31%)	7 (12%)
	HCP	0 (0%)	3 (17%)	3 (17%)	10 (56%)	2 (11%)	0 (0%)
Overall my (or the patient's) needs were able to be met using telehealth consultations?	**Patients**	2 (3%)	1 (2%)	8 (14%)	26 (45%)	15 (26%)	6 (10%)
	HCP	1 (6%)	3 (17%)	6 (33%)	6 (33%)	2 (11%)	1 (6%)
		Face-face alone		**Telehealth alone**	**Combination of face-face and telehealth**		**Not answered**
My preferred method of future palliative care service delivery would be?	***Patients***	14 (24%)		3 (5%)	35 (60%)		6 (10%)
	HCP	2 (11%)		0 (0%)	16 (89%)		0 (0%)

*Patients and HCP had the opportunity to provide free-text responses to any issues that they had encountered during telehealth consultations (either via telephone or video conferencing).

HCP, healthcare professionals.

video-based technologies is in keeping with previous data;[1] however, a recent study from Lebanon also reported high levels of both caregiver and provider satisfaction for a home-based palliative care telehealth programme that was predominantly telephone based.[5]

Both groups in the current survey reported issues when undertaking telehealth consultations; however, there were differences both in the proportion of respondents who had issues and the actual issues encountered. For patients, pre-existing sensory impairments and technical and experiential issues when using the technology were the predominant problems. In contrast, HCP were concerned about the inability to observe visual cues/body language or perform a physical examination and the potential negative impact this might have on the therapeutic relationship. While these would seem legitimate worries and have been reported previously, it is interesting patients mentioned them less frequently. Explanations for this discrepancy include the likelihood that patients were grateful for any form of contact with HCP and, perhaps even more so, with contact, which eliminated potential exposure to the coronavirus. While telehealth can never replicate the important benefits that physical touch brings,[15] there is evidence that patient satisfaction with therapeutic communication can be maintained via telehealth. Agha and colleagues[6] in an examination of patient satisfaction with physician–patient communication within pulmonary, endocrine and rheumatology clinics found patients were equally satisfied by the physician's ability to develop rapport and promote patient-centred communication whether in-person or via telemedicine.

There are a number of limitations to this study. It took place in a single, government-funded regional health service and; therefore, the findings may be less generalisable to metropolitan settings or jurisdictions without universal healthcare. As it was unknown at inception how things might evolve, we felt that the imperative was to quickly develop and distribute a simple and user friendly survey. This likely meant that the questionnaire, although both consumer and peer reviewed, was not able to be refined as much as may have been ideal. Due to the stressful times, the research team specifically decided patients would not be recontacted after receiving their initial survey. This meant it was not possible to assess longitudinal variations in perceptions of telehealth, which may have changed as COVID-19 continued to affect Victoria. While this study did not intend to assess clinical outcomes, this represents an important focus for future research evaluating palliative care service models that incorporate telehealth.

Adaptability is a crucial requirement for the success and sustainability of telehealth services,[14] meaning patient and HCP feedback will play a crucial role in evolving models that best meet consumer and clinician needs. While both patients and HCP in the current study endorsed the incorporation of telehealth into CPC practice, when given the opportunity to expand on issues encountered, they also highlighted individual and system barriers to effective utilisation. This information has already generated service improvements including the refinement of video-conferencing user guides and the upgrading of information technology software and hardware.

CONCLUSION

When specifically asked about their favoured model of CPC service provision, the majority of both patients and HCP indicated that their preference was a model that incorporated a combination of F2F and telehealth consultations. This study is one of the first to directly ask this question and as such provides important guidance for health services when planning future CPC service models.

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